STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE Regulation

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX **File No. 88572-001**
Petitioner
v

American Community Mutual Insurance Company
Respondent
_____/

Issued and entered
This 12th day of May 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On March 17, 2008, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. After a preliminary review of the material submitted the Commissioner accepted the request on March 24, 2008.

The issue in this matter can be decided by analyzing the American Community Mutual Insurance Company policy, the contract defining the Petitioner's health coverage. The Commissioner reviews contractual issues under MCL 500.1911(7). No medical issues are presented requiring analysis by an independent medical review organization.

II
FACTUAL BACKGROUND

Petitioner is covered under a fully insured individual policy underwritten by ACMIC. On December 14, 2007 the Petitioner was taken by ambulance to XXXXX where he sought emergency

treatment for severe back pain. The treating physician was XXXXX, DO. On January 14, 2008, as a follow-up to this emergency treatment, the Petitioner received a follow-up consultation with XXXXX MD of the XXXXX. Claims were submitted for the treatment. ACMIC initially denied the claims as related to a non-emergency illness that is excluded under the policy. But later processed the emergency claims under the emergency sickness benefits of the policy and the follow up appointment according to the physician office visit benefits, applying $1000.00 toward the 2007 calendar year deductible, copay and coinsurances for both dates of service.

The Petitioner appealed asking ACMIC to cover the services for the emergency services under the accident benefits. ACMIC reviewed the claims but upheld its decision and issued an adverse determination dated February 5, 2008.

III
ISSUE

Was American Community Mutual Insurance Company correct when it applied the charges for the Petitioner's emergency and follow-up visit to the deductibles, copays and coinsurances for 2007?

IV
ANALYSIS

Petitioner's Argument

The Petitioner received emergency care and follow-up care on December 25, 2007 and January 14, 2008 respectively. ACMIC allowed coverage for the emergency under the emergency illness benefits of its policy and the follow-up appointment as physician office benefits because there was no documentation of an injury. ACMIC determined eligible expenses to be $1,392.34 (applying $1000.00 to the deductible, $90.00 to copays and coinsurances and $28.02 in coinsurances) leaving the Petitioner responsible for $1,118.02.

Petitioner argues that the services should be covered under the accident benefits because he had no history of illness prior to December 25, 2007. In addition, at his follow-up appointment it was determined that he had a herniated disk. His physician advised him that "it's not unusual for a

patient to be unable to recall any specific injury" when they have this condition. He believes since he woke up with this pain, had no previous experience of injury that perhaps some accident occurred during the night. Therefore, he wants the benefits paid under the accident benefits where the deductible is waived if treatment is received within 30 days of the date of an injury.

American Community Mutual Insurance Company's Argument

ACMIC maintains that the Petitioner's claims were processed according to the provisions of his policy.

The Petitioner's policy has a calendar year deductible of $1,000.00, copays and coinsurance amounts for emergency illness and physician office visits. ACMIC says the benefits were in accordance with the policy

Commissioner's Review

The Commissioner has considered the arguments of both parties and the documentation presented, including the policy.

The Petitioner's certificate has a $1,000.00 per person calendar year deductible. The deductible is the amount of covered charges that the Petitioner must pay before ACMIC makes its payment. The policy also says, on pages 14, 16 and 18:

COVERED CHARGES	**NETWORK**	**NON-NETWORK**
Hospital Emergency Room Facility charges: **Emergency Sickness:** Co-payment is waived if admitted. **Emergency Injury:** Co-payment and Deductible are waived if Treatment is provided within 30 days of the date of the Injury. * * * **Hospital Emergency room Physicians Charges:**	You pay $50 Co-payment per visit, then subject to Network Deductible, then We pay: 90% You pay 10% You pay: $50 Co-payments per visit, then subject to Network Deductible, then We pay: 90% You pay: 10% Subject to Network Deductible, then We pay: 80% You pay: 10%	
Ambulance Services: For emergencies only	Subject to network Deductible, then We pay: 90% You pay: 10%	
COVERED CHARGES	**NETWORK**	**NON-NETWORK**
Accident Benefit:	Deductible is waived for any of the	

Applies when expenses are incurred due to an Injury	above covered services if treatment is received within 30 days of the date of an Injury. After 30 days normal plan benefits apply.

COVERED CHARGES – Services Provided in a Physicians Office and Urgent Care Center

COVERED CHARGES	NETWORK	NON-NETWORK
Visit for Sickness:	You pay: $40 Co-payment per visit; then We pay: 100%	You Pay: $80 Co-payment per visit; then We pay: 50% You pay: 50%
Visit for Injury: Copayment is waived if treatment is provided within 30 days of the date of the Injury. After 30 days from the date of the injury the co-payment will apply.	You pay $40 Co-payment per visit; then We pay: 100%	You pay: $80 Co-payment per visit; then We pay: 50% You pay: 50%

AMCIC defines an injury as "accidental bodily damage or loss". AMCIC concluded that Petitioner's pain was related to some kind of illness or disease (sickness) since he could not recall any accident or provide any documentation regarding an injury. The Petitioner argues that his services were for an accident and should be covered as such. However, he provides no documentation to support that an accident occurred. The record shows only that he woke up in pain and could not walk. Therefore, the Commissioner's role here is limited to deciding if ACMIC properly determined benefits under the terms and conditions of the certificate. AMCIC provided coverage as follows:

		A	B	C	D	E	F	G	H
Date of Service	Procedure	Total Charge	Not covered	Eligible Expenses (A-B)	Copay	Applied to Deductible	Total Considered (C-D& E)	Coinsurance Amount	Paid Amount (F-G)
12/25/07	A0427RF	475.00	75.00	400.00	0.00	400.00	0.00	0.00	0.00
	A0427RH	21.00	3.00	18.00	0.00	18.00	0.00	0.00	0.00
	99283	690.00	57.90	648.19	50.00[1]	582.00	16.19	1.62[3]	14.57
	Pharmacy	16.09							
	99283 ER visit	234.00	102.00	132.00	0.00	0.00	132.00	26.40[3]	105.60
01/14/08	99243	250.00	125.36	124.64	40.00[2]	0.00	84.64	0.00	84.64
	72110	216.00	146.49	69.51			69.51	0.00	69.51
	Total	1902.09	509.75	1392.34	90.00	1000.00	302.34	28.02	274.32

[1]Emergency sickness copayment, [2]Visit for sickness copayment and [3]10% Coinsurance

The Commissioner finds that ACMIC processed the claims correctly under the terms of the policy.

IV
ORDER

The Commissioner upholds ACMIC's adverse determinations of February 5, 2008. ACMIC correctly processed the Petitioner's claims for services in December 2007 and January 2008.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the Circuit Court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Regulation, Health Plans Division, P. O. Box 30220, Lansing, MI 48909-7720.

_____

Ken Ross
Commissioner